Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective September 15, 2025 (unless otherwise noted)

Note – Log-in is needed for policy update sections marked with an asterisk *. Use this link to log-in, Cigna for Health Care Professionals > Resources > Reimbursement and Payment Policies.

Medical Coverage Policy	New, Updated, or Retired?	Comments
Alveoloplasty - (0586)	New	**Posted 9/01/2025, Effective 12/01/2025** Important **changes** in coverage criteria: • The policy was created to address CPT codes on precert but not in any policy. • This policy is primarily based on benefit language and letter script language.
Cervical Plexus Block - (0579)	Updated	**Posted 6/15/2025; Effective 9/15/2025** Changed criteria from not covered or reimbursable to not medically necessary:
Dental Implants – (0585)	New	**Posted 9/01/2025, Effective 12/01/2025** Important **changes** in coverage criteria: • The policy was created to address CPT codes on precert but not in any policy. • This policy is primarily based on benefit language and letter script language.

Gender Dysphoria Treatment – (0266)	Updated	**Effective 8/18/2025** Minor **changes**: • Updated notes related to utilization management for New York fully insured plans.

Genetic Testing for Hereditary and Multifactorial Conditions – (0052)	Updated	**Posted Effective 10/11/2025**
		
		Minor **changes** in coverage criteria/policy:
		• Added section and statement for not covered or reimbursable tests.
		• Removed the following policy statements, as such testing is not implemented or otherwise managed via this policy:
		  • genetic testing and gene mapping in the general population
		  • genetic testing for global developmental delay and intellectual disability
		  • genetic testing for mitochondrial disorders
		  • newborn screening

Heart, Lung and Heart-Lung Transplantation – (0129)	Updated	Important **changes** in coverage criteria: • Expanding coverage to include when a transplant candidate has a history of malignancy
Hyperbaric and Topical Oxygen Therapies - (0053)	Updated	Important **changes** in coverage criteria/policy: • Removed policy statement that topical oxygen therapy is considered experimental, investigational, or unproven for all indications • Added a policy statement describing when topical oxygen therapy would be considered medically necessary • Added a policy statement that topical oxygen therapy would be considered not medically necessary for any other indication.
Inhaled Nitric Oxide (INO) – (0453)	Updated	**Posted 6/15/2025; Effective 9/15/2025** Important **changes** in coverage criteria: • Limited coverage of inhaled nitric oxide therapy to until the underlying oxygen desaturation has resolved, up to a maximum of 14 days. • Minor change to separate statement for vasoreactivity testing from therapeutic uses of inhaled nitric oxide.

Injectable Fillers for Head and Neck Conditions – (0511)	Updated	**Posted 6/15/2025; Effective 9/15/2025** Important **changes** in coverage criteria: ▪ Title change from Injectable Fillers to Injectable Fillers for Head and Neck Conditions ▪ Added a benefit coverage statement for injectable fillers ▪ Removed policy statement for laryngeal injection of hyaluronic acid with or without lidocaine (e.g. Restylane) due to CPT code Q4112 no longer being managed ▪ Expanded coverage by adding velopharyngeal insufficiency as a condition with medical necessity criteria ▪ Added a statement to refer to other policies for coverage criteria not specific to injectable fillers for head and neck conditions
Intraoral Prostheses – (0584)	New	**Posted 9/01/2025, Effective 12/01/2025** Important **changes** in coverage criteria: • The policy was created to address CPT codes on precert but not in any policy. • This policy is primarily based on benefit language and letter script language.
Laboratory Testing for Transplantation Rejection – (0465)	Updated	**Posted 6/15/2025 with effective date 9/15/2025** Important **changes** in coverage criteria: • Added Prospera back to the examples of experimental, investigational or unproven donor-derived cell-free DNA testing.
Lymphedema and Lipedema Surgical Treatments – (0531)	Updated	Minor **changes** in coverage criteria/policy: • Revised policy statement for lipedema to include hips and buttocks as part of extremities • Added not covered policy statement for treatment of lipedema in the trunk, abdomen, or back • Revised policy statement for microsurgical treatment to add lymph node-to-vein anastomosis [LVNA]) to list of examples
Minimally Invasive Anti-Reflux Procedures and Peroral Endoscopic Myotomy (POEM) Procedures – (0019)	Updated	Minor **changes** in coverage criteria/policy: • removing Zenker peroral endoscopic myotomy (Z-POEM) from the policy statement because the most accurate code for the procedure is not managed in any way
Nutritional Support – (0136)	Updated	Important **changes** in coverage criteria:

		• Title change: Moving from "Nutritional Support" to "Infant Nutritional Formula" to better align with the current scope of the policy. • Revised the existing benefit plan disclaimer to align with ICOG's standard benefit plan disclaimer to be consistent with the standard benefit plan disclaimer verbiage. • Removed the not medically necessary items statement because the associated HCPCS code for food thickeners (B4100) isn't clinically managed and lactose free products aren't implemented.
Open Neuroplasty Lumbar Plexus – (0587)	New	**Posted 9/1/2025, Effective 12/1/2025** Important changes in coverage criteria: • New CP addresses open surgical neuroplasty procedure involving the lumbar plexus (CPT® 64714). • Criteria for when procedure is considered medically necessary and when it is not medically necessary
Partial Rhinectomy, Rhinoplasty, Vestibular Stenosis Repair, and Septoplasty - (0119)	Updated	**Posted 6/15/2025; Effective 9/15/2025** Important **changes** in coverage criteria: • Updated CP Title to align with increased scope of policy: ➢ From: Rhinoplasty, Vestibular Stenosis Repair and Septoplasty ➢ To: Partial Rhinectomy, Rhinoplasty, Vestibular Stenosis Repair, and Septoplasty • Addition of codes on precert to coverage policy with corresponding criteria: ➢ 30150: Rhinectomy, partial (new coverage statement) ➢ 30620: Septal or other intranasal dermatoplasty (does not include obtaining graft) • Removal of unmanaged codes and corresponding statement
Prescription Digital Therapeutics - (0565)	New	**Posted 6/15/2025; Effective 9/15/2025. New CP**
Stem Cell Transplantation: Blood Cancers – (0533)	Updated	**Posting 9/15/2025; Effective 12/15/2025.** Important **changes** in coverage criteria: • Revised the policy statement for non-Hodgkin lymphoma by adding a separate not medically necessary policy statement for autologous hematopoietic stem cell transplantation (HSCT) in an adult with mycosis fungoides and Sézary syndrome to align with professional societies. • Revised the autologous HSCT policy statement for primary central nervous system lymphoma to include first remission as part of consolidation therapy.

Adjustable Continence Therapy – (0573)	Updated	• No change in coverage.
Benign Prostatic Hyperplasia (BPH) Surgical Treatments – (0159)	Updated	• No change in coverage.
Cervical Cancer Screening Visualization Technologies – (0127)	Updated	• No change in coverage.
Flow cytometry – (0538)	Updated	• No change in coverage.
High Intensity Focused Ultrasound (HIFU) – (0274)	Updated	**Posted 6/15/2025; Effective 9/15/2025** • No change in coverage.
Intraoperative Monitoring – (0509)	Updated	• No change in coverage.
Manipulation Under Anesthesia – (0276)	Updated	• No change in coverage.
Metatarsophalangeal Joint Replacement – (0446)	Updated	• No change in coverage.
Reflectance Confocal Microscopy – (0240)	Retired	• **Effective 9/10/2025** • No business value. • The code has been removed from edit.
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
Biofeedback – (CPG294)	Updated	**Posted 6/15/2025; Effective 9/15/2025:** Important **changes** in coverage criteria:

		• Limited coverage by adding the InTandem device to the existing EIU statement because the corresponding code is managed and the technology meets Cigna's definition of EIU. • Removed the Leva Pelvic Health System from the policy since the associated code isn't managed.
Electrodiagnostic Testing (EMG/NCV) – (CPG129)	Updated	• No change in coverage.
Occupational Therapy – (CPG155)	Updated	**Posted 6/15/2025; Effective 9/15/2025:** Important **changes** in coverage criteria: • Limited coverage by adding Low Frequency Non-Contact, Non-Thermal Ultrasound (MIST) to the existing EIU statement because the corresponding code is managed and the technology meets Cigna's definition of EIU.
Physical Therapy – (CPG135)	Updated	**Posted 6/15/2025; Effective 9/15/2025:** Important **changes** in coverage criteria: • Limited coverage by adding Low Frequency Non-Contact, Non-Thermal Ultrasound (MIST) to the existing EIU statement because the corresponding code is managed and the technology meets Cigna's definition of EIU.
Spinal Ultrasound – (CPG038)	Updated	• No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-EviCore Sleep Management Guidelines	Updated	**Posted 6/1/2025; Effective 9/1/2025** Important **changes** in coverage criteria. • Guidelines were updated with clinical changes that will limit coverage.

Cobranded Cigna-EviCore Guidelines Management of Unlisted Codes	New	**Posted 8/20/2025; Effective 12/1/2025** • **New guideline:** • Management of Unlisted Codes
Administrative Policy	**New, Updated, or Retired?**	**Comments**
Preventive Care Services – (A004)	Updated	Important **changes** in coverage criteria. • Adding Cologuard Plus as a covered test for Colorectal Cancer Screening (0464U) • Adding dual-energy X-ray absorptiometry (DXA) scan including vertebral fracture assessment (VFA) as a covered test for Osteoporosis Screening (77085, 77086) • Adding drug Yeztugo (lenacapavir) as covered for Prevention of HIV Infection: Preexposure Prophylaxis (PrEP) (J0738, J0752) • Adding drug Enflonsia (clesrovimab-cfor) as covered under Routine Immunizations for seasonal respiratory syncytial virus [RSV] (90382) • Adding a COVID vaccine as covered under Routine Immunizations for severe acute respiratory syndrome coronavirus 2 (SARS-CoV- 2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 10 mcg/0.2 mL dosage (91323) • Other minor corrections
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments**
Aflibercept - (IP0540)	Updated	**Effective: 9/15/2025** • **Employer Plans and Individual and Family Plans Preferred Product Criteria Tables.** **Updated** criteria language.
Amyloidosis – Wainua - (IP0628)	Updated	**Effective: 09/01/2025** • **Preferred Product Table.**

		• **Updated from "**Patient has tried Amvuttra; Patient has already been started on Wainua" **to** "Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with Amvuttra; Patient has already been started on therapy with Wainua"
Antifungals – Cresemba (Oral) – (IP0305)	Updated	**Effective: 9/15/2025** • **Aspergillus Infection – Treatment**: The duration of approval was changed to 6 months. Previously it was 3 months. • **Mucormycosis – Treatment**: The duration of approval was changed to 6 months. Previously it was 3 months. • **Esophageal Candidiasis in a Patient with Human Immunodeficiency Virus:** Previously this condition of approval was titled "Candidiasis (Systemic) in a Patient with Human Immunodeficiency Virus." • **Coccidioidomycosis in a Patient with Human Immunodeficiency Virus – Treatment**: New condition of approval was added to Other Uses with Supportive Evidence. • **Cryptococcal Meningitis – Treatment:** New condition of approval was added to Other Uses with Supportive Evidence.
Antifungals – Posaconazole (Oral) for Individual and Family Plans - (IP0536)	Updated	**Effective: 9/15/2025** • **Aspergillus Infection – Treatment.** The duration of approval for this condition was changed to 6 months. Previously, it was 3 months. • **Mucormycosis – Maintenance Treatment**: The duration of approval for this condition was changed to 12 months. Previously, it was 6 months. • **Cryptococcal Meningitis – Treatment**: New condition of approval was added to Other Uses with Supportive Evidence. • **Fungal Infection (Systemic) in a Patient with Human Immunodeficiency Virus Infection – Treatment**: The duration of approval for this condition was changed to 6 months. Previously it was 3 months.
Antifungals – Voriconazole (Oral) – (IP0306)	Updated	**Effective: 9/15/2025**

		• **Aspergillus Infection – Treatment:** The duration of approval for this condition was changed to 12 months. Previously, it was 3 months. • **Blastomycosis – Treatment:** The duration of approval for this condition was changed to 12 months. Previously, it was 3 months.
Antifungals – Tolsura - (IP0275)	Updated	**Effective: 9/15/2025** • **Aspergillosis – Pulmonary or Extrapulmonary – Treatment:** The duration of approval for this condition was changed to 6 months. Previously it was 3 months. • **Blastomycosis – Pulmonary or Extrapulmonary – Treatment:** The duration of aprpoval for this condition was changed to 12 months. Previously it was 6 months.
Antiseizure Medications - (IP0031)	Updated	**Effective 9/1/2025** • **Removed** Aptiom, Fycompa and Trokendi XR from the policy.
Antiseizure Medications – Ztalmy - (IP0508)	Updated	**Effective 9/15/2025** • **Added** documentation requirements throughout policy.
Brands with Bioequivalent Generics - (IP0011)	Updated	**Effective 9/1/2025** • **Removed for Employer Plans:** ○ Aczone 7.5% gel pump • **Added for Employer Plans:** Aptiom, Brilinta, Fycompa
Cholbam - (IP0289)	Updated	**Effective: 9/15/2025** • **Conditions Not Recommended for Approval**: Ctexli was added as a medication that should not be used concomitantly with Cholbam.
Complement Inhibitors – Fabhalta - (IP0614)	Updated	**Effective 9/1/2025** • **Conditions Not Recommended for Approval:**

		• **Added** new condition regarding concomitant use with other medications indicated for the treatment of immunoglobulin A nephropathy.
Contraceptives – Phexx - (IP0729)	Updated	**Effective 9/15/2025** • **Updated** policy statement to include the wording: "or for the improvement of birth outcomes."
Cushing's – Isturisa - (IP0044)	Updated	**Effective 9/15/2025** • **Updated** preferred product criteria for Employer Plans and Individual and Family Plans
Diabetes – Glucagon-Like Peptide-1 Agonists for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (IP0701)	Updated	**Effective 9/1/2025** • **Preferred Product Table:** • **Added** preferred product requirements for Byetta. • **Removed** preferred product requirements for Liragultide subcutaneous injection (generic for Victoza).
Drugs Requiring Medical Necessity Review for Employer Plans - (1602)	Updated	**Effective 9/1/2025** • **Added preferred product step requirement for the following products:** Retin-A micro gel 0.08% pump, tretinoin gel 0.08% pump, clemastine syrup, RyClora, carbinoxamine maleate 6 mg tablets, RyVent, amcinonide 0.1% ointment, ApexiCon E, Cordran Tape, diflorasone diacetate 0.05% cream, diflorasone diacetate 0.05% ointment, flurandrenolide 0.05% cream, flurandrenolide 0.05% ointment, flurandrenolide 0.05% lotion, hydrocortisone butyrate 0.1% lipid cream, hydrocortisone butyrate 0.1% lotion, Impoyz, Locoid, Locoid Lipocream, Pandel, alogliptin tablets (authorized generic for Nesina), Nesina, Onglyza, alogliptin and metformin tablets (authorized generic for Kazano), alogliptin and pioglitazone tablets (authorized generic for Oseni), Kazano, Kombiglyze XR, Oseni, Glumetza, metformin ER osmotic tablets, metformin ER gastric tablets, metformin immediate release 625

		mg tablets, budesonide extended release 9mg tablets, Uceris rectal foam, Uceris tablets, rabeprazole sodium delayed-release capsules (authorized generic of Aciphex Sprinkle), Alvesco, Advair Diskus, Advair HFA, AirDuo RespiClick, Breo Ellipta, fluticasone propionate/salmeterol HFA (authorized generic for Advair HFA), fluticasone propionate/salmeterol inhalation powder (authorized generic for AirDuo Respiclick), fluticasone furoate and vilanterol inhalation powder (authorized generic for Breo Ellipta), Symbicort, doxepin 5% cream, Prudoxin, and Zonalon. • **Updated preferred product step requirement for the following products:** Edarbi, Kenalog Spray, triamcinolone acetonide 0.147 mg/gm topical aerosol solution (generic Kenalog Spray), triamcinolone acetonide 0.05% ointment, Alkindi Sprinkle, sitagliptin tablets (authorized generic for Zituvio), Tradjenta, Zituvio, Jentadueto, Jentadueto XR, Qtern, Steglujan, Xultophy, Myrbetriq Granules, ArmonAir Digihaler, Arnuity Ellipta, Flovent Diskus, Flovent HFA, fluticasone propionate Diskus (authorized generic of Flovent Diskus), fluticasone propionate HFA (authorized generic of Flovent HFA), and Pulmicort Flexhaler.
Drugs Requiring Medical Necessity Review for Employer Plans (1602)	Updated	**Effective 9/15/2025** • **Added preferred product step requirement for the following products:** ○ Raldesy and Fanapt titration pack
Gamifant - (IP0113)	Updated	**Effective 9/15/2025** • **Added "<u>Documentation</u>:** Documentation is required where noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information." • **Hemophagocytic Lymphohistiocytosis/Macrophage Activation Syndrome (HLH/MAS):** This new condition of approval was added.
HIV Products - (P0050)	Updated	**Effective 9/1/2025** • **Preferred product table** • **Added** preferred product requirements for Complera. • **Appendix 1** • **Removed** generic emtricitabline/rilpivirine/tenofovir disoproxil fumarate tablet.

Lupus – Benlysta Subcutaneous - (IP0430)	Updated	**Effective 9/1/2025** • **Lupus Nephritis**: For initial therapy, the age requirement was updated to ≥ 5 years of age. Previously, the requirement was ≥ 18 years of age.
Immunologicals – Dupixent - (IP0453)	Updated	**Effective 9/1/2025** • **Bullous Pemphigoid:** This condition and criteria for approval were added to the policy.
Infectious Disease – Sirturo - (IP0494)	Updated	**Effective 9/15/2025** • **Tuberculosis.** The approved duration for this condition was changed to 6 months. Previously, it was 9 months.
Inflammatory Conditions – Adalimumab Products Prior Authorization Policy – (IP0652)	Updated	**Effective 9/1/2025** • **Ulcerative Colitis:** For initial therapy, removed the following options of approval: (1) the patient has tried one systemic therapy; (2) the patient has pouchitis and tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema.
Inflammatory Conditions – Entyvio Intravenous Prior Authorization Policy – (IP0674)	Updated	**Effective 9/1/2025** • **Ulcerative Colitis:** For initial therapy, removed the following options of approval: (1) the patient has tried one systemic therapy; (2) the patient has pouchitis and tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema.
Inflammatory Conditions – Entyvio Subcutaneous Prior Authorization Policy – (IP0675)	Updated	**Effective 9/1/2025** • **Ulcerative Colitis:** For initial therapy, removed the following options of approval: (1) the patient has tried one systemic therapy; (2) the patient has pouchitis and tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema.
Inflammatory Conditions – Infliximab Intravenous Products	Updated	**Effective 9/1/2025**

Prior Authorization Policy – (IP0660)		• **Ulcerative Colitis:** For initial therapy, removed the following options of approval: (1) the patient has tried one systemic therapy; (2) the patient has pouchitis and tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema.
Inflammatory Conditions – Omvoh Intravenous Prior Authorization Policy – (IP0662)	Updated	**Effective 9/1/2025** • **Ulcerative Colitis:** For initial therapy, removed the following options of approval: (1) the patient has tried one systemic therapy; (2) the patient has pouchitis and tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema.
Inflammatory Conditions – Omvoh Subcutaneous Prior Authorization Policy – (IP0663)	Updated	**Effective 9/1/2025** • **Ulcerative Colitis:** For initial therapy, removed the following options of approval: (1) the patient has tried one systemic therapy; (2) the patient has pouchitis and tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema.
Inflammatory Conditions – Simponi Subcutaneous Prior Authorization Policy – (IP0667)	Updated	**Effective 9/1/2025** • **Ulcerative Colitis:** For initial therapy, removed the following options of approval: (1) the patient has tried one systemic therapy; (2) the patient has pouchitis and tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema.
Inflammatory Conditions – Skyrizi Intravenous Prior Authorization Policy – (IP0669)	Updated	**Effective 9/1/2025** • **Ulcerative Colitis:** For initial therapy, removed the following options of approval: (1) the patient has tried one systemic therapy; (2) the patient has pouchitis and tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema.
Inflammatory Conditions – Skyrizi Subcutaneous Prior Authorization Policy – (IP0670)	Updated	**Effective 9/1/2025** • **Ulcerative Colitis:** For initial therapy, removed the following options of approval: (1) the patient has tried one systemic therapy; (2) the patient has pouchitis and tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema.

Inflammatory Conditions – Tremfya Intravenous Prior Authorization Policy – (IP0704)	Updated	**Effective 9/1/2025** • **Ulcerative Colitis:** For initial therapy, removed the following options of approval: (1) the patient has tried one systemic therapy; (2) the patient has pouchitis and tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema.
Inflammatory Conditions – Tremfya Subcutaneous Prior Authorizations Policy – (IP0689)	Updated	**Effective 9/1/2025** • **Ulcerative Colitis:** For initial therapy, removed the following options of approval: (1) the patient has tried one systemic therapy; (2) the patient has pouchitis and tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema.
Inflammatory Conditions – Velsipity Prior Authorization Policy – (IP0691)	Updated	**Effective 9/1/2025** • **Ulcerative Colitis:** For initial therapy, removed the following options of approval: (1) the patient has tried one systemic therapy; (2) the patient has pouchitis and tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema.
Inflammatory Conditions – Zymfentra Prior Authorization Policy – (IP0646)	Updated	**Effective 9/1/2025** • **Ulcerative Colitis:** For initial therapy, removed the following options of approval: (1) the patient has tried one systemic therapy; (2) the patient has pouchitis and tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Legacy Drug List Plans - (PSM003)	Updated	**Effective 9/1/2025** • **Adalimumab-adaz:** removed "Patient is currently taking adalimumab-adaz" as an option of approval to allow continuation of therapy. The same exception criteria will now apply for all of the Non-Preferred Products.
Inflammatory Conditions – Adalimumab Products Preferred Specialty	Updated	**Effective 9/1/2025.**

Management Policy: Standard/Performance, Value/Advantage, and Total Savings Prescription Drug Lists - (PSM013)		• **Adalimumab-adaz:** removed "Patient is currently taking adalimumab-adaz" as an option of approval to allow continuation of therapy. The same exception criteria will now apply for adalimumab-adaz as for all of the other Step 3 Non-Preferred Products.
Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists Plans - (PSM009)	Updated	**Effective 9/1/2025** • **Ankylosing Spondylitis and Psoriatic Arthritis:** adalimumab-adaz was removed as a Preferred Product. • Throughout the policy, the note was updated for the examples of ustekinumab products which include Stelara, ustekinumab (unbranded Stelara), Imuldosa, Otulfi, Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, Wezlana, and Yesintek.
Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Legacy Prescription Drug Lists Plans - (PSM016)	Updated	**Effective 9/1/2025** • **Ankylosing Spondylitis and Psoriatic Arthritis:** adalimumab-adaz was removed as a Preferred Product. Humira was updated to clarify "NDCs starting with 00074", rather than "by AbbVie". • Throughout the policy, the note was updated for the examples of ustekinumab products which include Stelara, ustekinumab (unbranded Stelara), Imuldosa, Otulfi, Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, Wezlana, and Yesintek.
Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy for Individual and Family Plan	Updated	**Effective 9/1/2025** • Ustekinumab intravenous (unbranded Stelara [Janssen]) was added to the policy as a Preferred product. • Throughout the policy, the note was updated for the examples of ustekinumab products which include Stelara, ustekinumab (unbranded Stelara), Imuldosa, Otulfi,

Prescription Drug Lists – (PSM011)		Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, Wezlana, and Yesintek.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists - (PSM006)	Updated	**Effective 9/1/2025** • **For All Conditions,** adalimumab-adaz was removed as a Preferred Product. • Throughout the policy, the note was updated for the examples of ustekinumab products which include Stelara, ustekinumab (unbranded Stelara), Imuldosa, Otulfi, Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, Wezlana, and Yesintek.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Legacy Prescription Drug Lists - (PSM018)	Updated	**Effective 9/1/2025** • **For All Conditions,** adalimumab-adaz was removed as a Preferred Product. • Throughout the policy, the note was updated for the examples of ustekinumab products which include Stelara, ustekinumab (unbranded Stelara), Imuldosa, Otulfi, Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, Wezlana, and Yesintek.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Individual and Family Plans - (PSM010)	Updated	**Effective 9/1/2025** • Throughout the policy, the note was updated for the examples of ustekinumab products which include Stelara, ustekinumab (unbranded Stelara), Imuldosa, Otulfi, Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, Wezlana, and Yesintek.
Inflammatory Conditions – Siliq Prior Authorization Policy - (IP0685)	Updated	**Effective 9/1/2025** • **Plaque Psoriasis.** Initial approval and for a patient currently receiving Siliq: The requirement that the prescriber attests the patient has been assessed and evaluated for risks of suicidal ideation or behavior versus benefits of therapy was modified to

		"According to the prescriber, the patient has been evaluated for these risks versus benefits of therapy". "According to the prescriber" was added to the requirement that the patient does not have moderately severe to severe depression. Initial approval: "According to the prescriber" was added to the requirement that within the past 5 years, the patient does not have a history of suicidal ideation or suicidal behavior.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Standard/Performance, Value/Advantage, and Total Savings Prescription Drug Lists – (PSM021)	Updated	**Effective 9/1/2025** • **Ustekinumab and Ustekinumab-aekn:** These agents were added as Non-Preferred subcutaneous products. Requests for ustekinumab are directed to Stelara and requests for ustekinumab-aekn are directed to Selarsdi. • **For Ustekinumab 45mg subcutaneous vial:** the following note was added to the Preferred and Non-Preferred Products table "Note: Ustekinumab subcutaneous injection (Janssen Biotech) 45mg vial is covered as a preferred product on the medical benefit only; for pharmacy benefit coverage refer to the criteria in the table below." ○ Appendix was updated to remove adalimumab-adaz from the list of Other (Non-Ustekinumab) Preferred Products.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Legacy Prescription Drug List Plans – (PSM022)	Updated	Effective 9/1/2025 **Ustekinumab and Ustekinumab-aekn:** These agents were added as Non-Preferred subcutaneous products. Requests for ustekinumab are directed to Stelara and requests for ustekinumab-aekn are directed to Selarsdi. **For Ustekinumab 45mg subcutaneous vial,** the following note was added to the Preferred and Non-Preferred Products table "Note: Ustekinumab subcutaneous injection (Janssen Biotech) 45mg vial is covered as a preferred product on the medical benefit only; for pharmacy benefit coverage refer to the criteria in the table below." Appendix was updated to remove adalimumab-adaz from the list of Other (Non-Ustekinumab) Preferred Products.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred	Updated	**Effective 9/1/2025** • **Ustekinumab and Ustekinumab-aekn:** These agents were added as Non-Preferred subcutaneous products. Requests for ustekinumab are directed to Stelara and requests for ustekinumab-aekn are directed to Selarsdi.

Specialty Management Policy for Individual and Family Plans – (PSM023)		• **For Ustekinumab 45mg subcutaneous vial,** the following note was added to the Preferred and Non-Preferred Products table "Note: Ustekinumab subcutaneous injection (Janssen Biotech) 45mg vial is covered as a preferred product on the medical benefit only; for pharmacy benefit coverage refer to the criteria in the table below."
Inflammatory Conditions – Ustekinumab Intravenous Products Preferred Specialty Management Policy - (PSM024)	Updated	**Effective 9/1/2025** • Ustekinumab intravenous (unbranded Stelara [Janssen]) was added to the policy as a Preferred product.
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists - (PSM001)	Updated	Effective 9/1/2025 • **Adalimumab-adaz** was removed as a Preferred Product throughout the policy. • Throughout the policy, the note was updated for the examples of ustekinumab products which include Stelara, ustekinumab (unbranded Stelara), Imuldosa, Otulfi, Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, Wezlana, and Yesintek.
Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)	Updated	**Effective 9/1/2025** • Throughout the policy, the note was updated for the examples of ustekinumab products which include Stelara, ustekinumab (unbranded Stelara), Imuldosa, Otulfi, Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, Wezlana, and Yesintek.
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Legacy	Updated	**Effective 9/1/2025** • **Adalimumab-adaz** was removed as a Preferred Product throughout the policy. • Throughout the policy, the note was updated for the examples of ustekinumab products which include Stelara, ustekinumab (unbranded Stelara), Imuldosa, Otulfi,

Prescription Drug Lists – (PSM017)		Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, Wezlana, and Yesintek.
Inflammatory Conditions – Otezla Prior Authorization Policy - (IP0666)	Updated	**Effective 9/15/2025** • **Psoriatic Arthritis:** Expanded age requirement from ≥ 18 to ≥ 6 years of age.
Iron Replacement – Monoferric - (IP0749)	New	**Effective 9/15/2025** • New policy
Iron Replacement – Feraheme - (IP0750)	New	**Effective 9/15/2025** • New policy
Iron Replacement – Injectafer - (IP048)	New	**Effective 9/15/2025** • New policy
Metabolic Disorders – Tiopronin - (IP0202)	Updated	**Effective 9/1/2025** • **Employer Plans Preferred Product Table:** • Added Venxxiva CR tablets as alternative to Thiola EC • **Individual and Family Plans Preferred Product Table:** • Added tiopronin delayed-release tablets • **Updated** documentation requirements throughout policy
Multiple Sclerosis and Ulcerative Colitis (Oral – Sphingosine 1-Phosphate Receptor Modulator) – Zeposia Prior Authorization Policy – (IP0655)	Updated	**Effective 9/1/2025** • The name of the policy was changed to add "Oral – Sphingosine 1-Phosphate Receptor Modulator". In addition, the following changes were made: • **Multiple Sclerosis:** Extavia was removed from Appendix B (it's obsolete). • **Ulcerative Colitis:** For Initial Therapy, the requirement that the patient has tried ONE systemic agent for ulcerative colitis was removed, along with the related Note.

		Appendix A was updated to note that biosimilars are available to Stelara, as well as an update to the list of indications.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy for Individual and Family Plans - (PSM008)	Updated	**Effective 9/1/2025** • **Ulcerative Colitis:** the note was updated for the examples of ustekinumab products which include Stelara, ustekinumab (unbranded Stelara), Imuldosa, Otulfi, Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, Wezlana, and Yesintek.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy for Legacy Prescription Drug List Plans - (PSM004)	Updated	**Effective 9/1/2025** • **Ulcerative Colitis:** adalimumab-adaz was removed as a Preferred Product. The note was updated for the examples of ustekinumab products which include Stelara, ustekinumab (unbranded Stelara), Imuldosa, Otulfi, Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, Wezlana, and Yesintek.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy: Standard/Performance, Value/Advantage, Total Savings Prescription Drug List Plans - (PSM015)	Updated	**Effective 9/1/2025** • **Ulcerative Colitis:** adalimumab-adaz was removed as a Preferred Product. The note was updated for the examples of ustekinumab products which include Stelara, ustekinumab (unbranded Stelara), Imuldosa, Otulfi, Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, Wezlana, and Yesintek.
Migraine – Nurtec ODT - (IP0147)	Updated	**Effective 9/1/2025** • **Employer Plans and Individual and Family Plans Preferred Product Criteria Tables.** • **Added** "The patient has tried and experienced inadequate efficacy or significant intolerance to one triptan/non-steroidal anti-inflammatory drug (NSAID) combination

		product OR the patient has tried and experienced inadequate efficacy or significant intolerance to a triptan taken concomitantly with an NSAID" exception criteria.
Migraine – Zavzpret - (IP0573)	Updated	**Effective 9/1/2025** • **Employer Plans and Individual and Family Plans Preferred Product Criteria Tables.** • **Added "**The patient has tried and experienced inadequate efficacy or significant intolerance to one triptan/non-steroidal anti-inflammatory drug (NSAID) combination product OR the patient has tried and experienced inadequate efficacy or significant intolerance to a triptan taken concomitantly with an NSAID" exception criteria.
Migraine – Reyvow - (IP0114)	Updated	**Effective 9/1/2025** • **Employer Plans and Individual and Family Plans Preferred Product Criteria Tables.** • **Added "**The patient has tried and experienced inadequate efficacy or significant intolerance to one triptan/non-steroidal anti-inflammatory drug (NSAID) combination product OR the patient has tried and experienced inadequate efficacy or significant intolerance to a triptan taken concomitantly with an NSAID" exception criteria.
Nephrology – Filspari - (IP0565)	Updated	**Effective 9/1/2025** • **Updated policy statement** • **Conditions Not Recommended for Approval:** Added new condition regarding concomitant use with other medications indicated for the treatment of immunoglobulin A nephropathy.
Oncology – Imbruvica for Non-Oncology Uses - (IP0320)	Updated	**Effective: 09/01/2025** • **Graft-Versus-Host Disease, Chronic:** The requirement that the patient has tried at least "one conventional systemic treatment" for graft-versus-host disease was reworded to "one systemic medication for graft-versus-host disease". The following medications were added to the Note of examples of a systemic regime: Rezurock

		(belumosudil tablets), Niktimvo (axatilimab-csfr intravenous infusion), hydroxychloroquine, rituximab, pentostatin, interleukin-2 (e.g., Proleukin [aldesleukin intravenous infusion]), cyclosporine, tacrolimus, sirolimus, an etanercept product.
Oncology Medications - (1403)	Updated	**Effective: 09/01/2025** **Ensacove.** • **Added** criteria for Ensacove for Individual and Family Plan **Onivyde.** • **Pancreatic Adenocarcinoma:** Removed the requirement that patient has been previously treated with fluoropyrimidine-based therapy without irinotecan. Added "according to prescriber patient is Eastern Cooperative Oncology Group Performance Status 0 or 1 and has tried a gemcitabine-based regimen" and "according to prescriber patient is Eastern Cooperative Oncology Group Performance Status 0 or 1 and has tried a flouropyrimidine-based regimen but without prior irinotecan" as options for approval. **Ampullary adenocarcinoma:** Added ampullary adenocarcinoma as a new condition for approval.
Ophthalmology – Dry Eye Disease Cyclosporine Ophthalmic Products - (IP0026)	Updated	**Effective 9/1/2025** • **Employer Plan Preferred Product Table.** • **Removed** Restasis vial preferred product requirements.
Ophthalmology – Dry Eye Disease Cyclosporine Ophthalmic Products - (IP0026)	Updated	**Effective 9/15/2025** • **Conditions Not Recommended for Approval:** Tryptyr was added to the list of medications that should not be used concomitantly with the requested cyclosporine product.
Ophthalmology – Dry Eye Disease – Tyrvaya for Individual and Family Plans - (IP0395)	Updated	**Effective 9/15/2025** • **Conditions Not Recommended for Approval:** Tryptyr was added to the list of medications that should not be used concomitantly with Tyrvaya.

Ophthalmology – Dry Eye Disease – Xiidra for Individual and Family Plans – (IP0644)	Updated	**Effective 9/15/2025** • **Conditions Not Recommended for Approval:** Tryptyr was added to the list of medications that should not be used concomitantly with Tyrvaya.
Opioid Therapy - Employer Group Benefit Plans - (IP0561)	Updated	**Effective 9/15/2025** • Updated policy with clarification regarding Methadone for the treatment of Opioid Use Disorder (OUD)
Opioid Therapy – Individual and Family Plans - (IP0562)	Updated	**Effective 9/15/2025** • Updated policy with clarification regarding Methadone for the treatment of Opioid Use Disorder (OUD)
Parkinson's Disease – Onapgo – (IP0746)	New	**Effective 9/1/2025** • New Policy.
Pharmacy Prior Authorization - (1407)	Updated	**Effective 9/1/2025** • **Added** Individual and Family Plan product-specific medical necessity criteria: azelaic acid 15% gel, Combogesic, Arbli, Edarbi, Ryclora, carbinoxamine maleate 6 mg tablets, RyVent, Lamictal XR starter, sitagliptin and metformin hydrochloride extended-release tablets (authorized generic for Zituvimet XR), Glumetza (metformin extended-release tablets), Fortamet (metformin extended-release tablets), Metformin ER osmotic tablets (Fortamet). Metformin ER tablets (Glumetza), metformin immediate release 625 mg tablets, Symbravo, Zelsuvmi, ibuprofen 800mg and famotidine 26.6mg tablet, naproxen and esomeprazole magnesium 375 mg/20 mg or 500 mg/20 mg delayed-release tablet, Vimovo, rabeprazole sodium delayed-release capsules (authorized generic of Aciphex Sprinkle), Yosprala, Hemiclor, and Renthyroid • **Updated** Individual and Family Plan product-specific medical necessity criteria: Alkindi Sprinkle, alogliptin tablet (Nesina authorized generic), Nesina, Onglyza, alogliptin and metformin tablets (Kazano authorized generic), alogliptin and

		pioglitazone tablets (Oseni authorized generic), Kazano, Kombiglyze XR, Oseni, Glyxambi, Qtern, Steglujan, Trijardy XR, Dolobid, Myrbetriq Granules, Auryxia, ferric citrate tablets (Auryxia authorized generic), ArmonAir Digihaler, Flovent Diskus, Flovent HFA, fluticasone propionate HFA (authorized generic of Flovent HFA), fluticasone inhalation powder (authorized generic of Flovent Diskus), Pulmicort Flexhaler, Airsupra, Advair HFA, AirDuo Digihaler, AirDuo RespiClick, fluticasone propionate/ salmeterol inhalation powder (AirDuo Respiclick authorized generic), fluticasone furoate and vilanterol inhalation powder, fluticasone propionate/salmeterol HFA oral inhalation, Breztri Aerosphere, and Inzirqo • **Removed** Individual and Family Plan product-specific medical necessity criteria: Onapgo
Step Therapy Individual and Family Plans - (1603)	Updated	**Effective 9/1/2025** • **Added** Insulin Aspart Pro Mix 70-30 Vial as an Insulin, short-acting Step 2 product.
Thrombocytopenia – Doptelet - (IP0152)	Updated	**Effective 9/1/2025** • **Added** documentation requirements throughout the policy.
Thrombocytopenia – Eltrombopag Products - (IP0153)	Updated	**Effective 9/1/2025** • **Added** documentation throughout the policy. • **Preferred Product Table** • **Added** preferred product requirements for Promacta tablets and oral suspension for Employer Plans. • **Updated** the Employer Plans and Individual and Family Plans preferred product requirements for Alvaiz.
Thrombocytopenia – Eltrombopag Products - (IP0153)	Updated	**Effective 9/15/2025** • **Updated** the Employer Plans and Individual and Family Plans preferred product requirements for Alvaiz.

Thrombocytopenia – Mulpleta - (IP0156)	Updated	**Effective 9/1/2025** • **Added** documentation requirements throughout the policy.
Thrombocytopenia – Nplate - (IP0155)	Updated	**Effective 9/1/2025** • **Added** documentation requirements throughout the policy.
Thrombocytopenia – Tavalisse - (IP0154)	Updated	**Effective 9/1/2025** • **Added** documentation requirements throughout the policy.
Tolvaptan Products – Tolvaptan (Jynarque) - (IP0287)	Updated	**Effective 9/1/2025** • The policy was renamed to Tolvaptan Products – Tolvaptan (Jynarque) Prior Authorization Policy. Previously, the policy was named Tolvaptan Products – Jynarque. Jynarque tablets are now available as a generic product. • **Autosomal Dominant Polycystic Kidney Disease.** Mayo Classification 1C was added to the Note of examples for rapidly progressing autosomal dominant polycystic kidney disease. • **Autosomal Dominant Polycystic Kidney Disease.** The requirement regarding kidney function was updated to state that the patient has an estimated glomerular filtration rate ≥ 25 mL/min/1.73 m^2. Previously, it stated that a patient did not have Stage 5 chronic kidney disease, which was defined in the Note as glomerular filtration rate < 15 mL/min/1.73 m^2. With the updated criterion, the related note was deleted. • The requirement that a patient has an eGFR ≥ 25 mL/min^2 was clarified to state that this was a requirement at baseline. A corresponding Note was added to define baseline as prior to treatment with any tolvaptan product. Another requirement was also added that a patient on tolvaptan therapy cannot be on renal replacement therapy. A corresponding Note was added to define renal replacement therapy as dialysis or transplantation. • **Employer Plans Preferred Product table.** • **Added** preferred product requirement criteria for brand Jynarque tablets and brand Jynarque therapy pack.

Topical Acne – Non-Retinoid Products - (IP0166)	Updated	**Effective 9/1/2025** • **Employer preferred product table** • **Removed** Onexton preferred product requirements.
Uplizna - (IP0062)	Updated	**Effective 9/1/2025** • **Immunoglobulin G4-Related Disease:** Initial Therapy: Criterion regarding confirmation of IgG4-RD diagnosis was added: Diagnosis of IgG4-RD is confirmed by at least one of the following: a biopsy of at least one involved organ and immunostaining confirms presence of IgG-positive cells; or imaging; or elevated IgG4 levels and histopathologic features.
Vasculitis – Tavneos - (IP0398)	Updated	**Effective 9/1/2025** • **Anti-Neutrophil Cytoplasmic Autoantibody (ANCA)-Associated Vasculitis:** The requirement for use of Tavneos in combination with an immunosuppressant was clarified to "nonglucocorticoid" immunosuppressant for ANCA-associated vasculitis. Cyclophosphamide was added as an example of a nonglucocorticoid immunosuppressant. Pulmonologist was added as an accepted specialist to the specialist requirement.
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 30 - (IP0206)	Updated	**Effective 9/15/2025** Saxenda: • **Weight Loss in an Adult with Overweight or Obesity.** This condition of approval was modified to add "with obesity or is overweight". • **Weight Loss in a Pediatric Patient with Obesity.** This condition of approval was modified to add "with obesity". Wegovy: • **Weight Loss in an Adult with Overweight or Obesity.** This condition of approval was modified to add "with obesity or is overweight". • **Weight Loss in a Pediatric Patient with Obesity.** This condition of approval was modified to add "with obesity".

		• **Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease in a Patient with Obesity or Overweight.** This condition of approval was re-worded from "in an overweight or obese patient" to "in a patient with obesity or is overweight". Zepbound: • **Weight Loss in an Adult with Overweight or Obesity.** This condition of approval was modified to add "with obesity or is overweight".
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 32 - (IP0621)	Updated	**Effective 9/15/2025** • **Policy Statement:** The Policy Statement was updated to add that the policy authorizes coverage non-weight loss based on FDA-approved indications as applicable (see authorization criteria for details). Saxenda • **Weight Loss in an Adult with Overweight or Obesity.** This condition of approval was modified to add "with obesity or is overweight". • **Weight Loss in a Pediatric Patient with Obesity.** This condition of approval was modified to add "with obesity". Wegovy • **Weight Loss in an Adult with Overweight or Obesity.** This condition of approval was modified to add "with obesity or is overweight". • **Weight Loss in a Pediatric Patient with Obesity.** This condition of approval was modified to add "with obesity". • **Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease in a Patient with Overweight or Obesity.** A new condition of approval was added. Zepbound • **Weight Loss in an Adult with Overweight or Obesity.** This condition of approval was modified to add "with obesity or is overweight". • **Obstructive Sleep Apnea, Moderate to Severe, in a Patient with Obesity.** A new condition of approval was added.

Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 35 - (IP0739)	Updated	**Effective 9/15/2025** • **Policy Statement:** The Policy Statement was updated to add that the policy authorizes coverage non-weight loss based on FDA-approved indications as applicable (see authorization criteria for details). Saxenda • **Weight Loss in an Adult with Overweight or Obesity.** This condition of approval was modified to add "with obesity or is overweight". • **Weight Loss in a Pediatric Patient with Obesity.** This condition of approval was modified to add "with obesity". Wegovy • **Weight Loss in an Adult with Overweight or Obesity.** This condition of approval was modified to add "with obesity or is overweight". • **Weight Loss in a Pediatric Patient with Obesity.** This condition of approval was modified to add "with obesity". Zepbound • **Weight Loss in an Adult with Overweight or Obesity.** This condition of approval was modified to add "with obesity or is overweight".
Cardiology – Camzyos (IP0480)	Updated	**Effective: 9/1/2025** • No criteria changes.
Cystic Fibrosis Transmembrane Conductance Regulator – Orkambi (IP0432)	Updated	**Effective 9/1/2025** • No criteria changes
Enzyme Replacement Therapy – Elfabrio PA (IP0570)	Updated	**Effective: 9/1/2025** • No criteria changes.

Erythropoiesis-Stimulating Agents - Aranesp (IP0293)	Updated	**Effective: 9/15/2025** • No criteria changes.
Erythropoiesis-Stimulating Agents – Epoetin Alfa Products (IP0296)	Updated	**Effective: 9/15/2025** • No criteria changes.
Gastroenterology – Gattex (IP0288)	Updated	**Effective: 9/1/2025** • No criteria changes.
Hematology – Rytelo (IP0693)	Updated	**Effective: 9/1/2025** • No criteria changes.
Inflammatory Conditions – Litfulo Prior Authorization Policy - (IP0680)	Updated	**Effective: 9/1/2025** • No criteria changes.
Inpefa (IP0582)	Updated	**Effective: 9/15/2025** • No change in coverage
Lipodystrophy – Myalept (IP0340)	Updated	**Effective: 9/15/2025** • No change in coverage.
Lofexidine for Individual and Family Plans (IP0696)	Updated	**Effective: 9/15/2025** • No criteria changes.
Neurology – Oxybate (IP0103)	Updated	**Effective: 9/1/2025**

		• No criteria changes.
Neurology – Qalsody (IP0567)	Updated	**Effective: 09/01/2025** • No change in coverage.
Tolvaptan Products – Tolvaptan (Samsca) (IP0471)	Updated	**Effective: 9/1/2025** • No criteria changes.
Vecamyl for Individual and Family Plans (IP0650)	Updated	**Effective: 9/15/2025** • No change in coverage
Wakefulness-Promoting Agents – Wakix (IP0292)	Updated	**Effective: 09/01/2025** • No change in coverage
Corticosteroid/Long-Acting Beta2-Agonist Combination Inhalers - (IP0022)	Retired	**Effective: 09/01/2025** • *Products have been relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602)*
Budesonide - (P0084)	Retired	**Effective: 09/01/2025** • *Products have been relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602)*
Antihyperglycemic Therapy (Non-Insulin) - (P0098)	Retired	**Effective: 09/01/2025** • *Products have been relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602)*

Intravenous Iron Replacement - (IP0222)	Retired	**Effective: 09/15/2025** • ***Feraheme, Ferumoxytol*** *relocated to Iron Replacement – Feraheme (IP0750)* • ***Injectafer*** *relocated to Iron Replacement – Injectafer (IP0748)* • ***Monoferric*** *relocated to Iron Replacement – Monoferric (IP0749)*
Oral Antihistamines - (IP0190)	Retired	**Effective: 09/01/2025** • *Products have been relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602)*
Topical Doxepin Cream - (IP0207)	Retired	**Effective: 09/01/2025** • *Products have been relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602)*
Topical Corticosteroids - (IP0281)	Retired	**Effective: 09/01/2025** *Products have been relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602)*
CareAllies Medical Necessity Guideline	**New, Updated, or Retired?**	**Comments**
		• All above updates apply
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
September 2025 Prior Authorization Requirements Commercial	Updates	• Updated prior authorization requirements are available on our website, CignaforHCP.Cigna.com. • For September 12, 2025, Cigna removed 4 CPT and 1 HCPCS codes from prior authorization.

Reimbursement Policy*	New, Updated, or Retired?	Comments
		• No updates for September 2025
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**
		• No updates for September 2025
ClaimsXten Documents*	**New, Updated, or Retired?**	**Comments**
	Update	• No updates for September 2025